

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  106155	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/08/2026
NAME OF PROVIDER OR SUPPLIER  Victoria Crossing Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  701 Victoria St Brandon, FL 33510	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0627  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	<p>Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge.</p> <p>Based on record review and interview, the facility failed to allow the resident to remain in the facility during a pending appeal for one resident (#133) out of four residents reviewed for discharge. Findings Included: Review of Resident #133's admission record revealed an admission date of 10/01/2025 and a discharge date of 11/04/2025. Resident #133 was admitted to the facility with diagnosis to include orthopedic aftercare following surgical amputation, other acute osteomyelitis, left ankle and foot, chronic obstructive pulmonary disease, and muscle weakness. Review of a care plan for Resident #133 initiated on 10/03/2025 revealed a focus; [Resident #133] wishes to return home with her [family member]. The goal showed the resident will be able to verbalize/communicate required assistance post-discharge and the services required to meet needs before discharge. Interventions included to encourage resident to discuss feelings and concerns impeding discharge. Establish a pre-discharge plan with the resident/resident representative and evaluate the process. SS (Social Services) will make arrangements with required community resources to support independence post discharge. Review of a Physical Therapy (PT) discharge summary dates 10/2/2025 - 11/3/2025 showed Resident #133's plan was to discharge home. The discharge reason showed - Highest practical level achieved. Discharge recommendations showed Home health services were recommended. The summary did not show if Resident #133's home health services were set up prior to discharge. Review of the State of Florida Department of Children and Families (DCF) appeal hearing form revealed an appeal for discharge for Resident #133 was filed on 11/03/2025. The document revealed this hearing was based on the patient's belief that he/she was being erroneously discharged from the nursing facility. Review of Resident #133's electronic medical record revealed there was no record or notes related to Resident #133 or representative filing an appeal. The review of the entire clinical record did not show why the resident may not have been ready to discharge from the facility. Attempts to reach the resident were unsuccessful. An interview was conducted on 01/08/2026 at 3:56 p.m. with the Social Services Director (SSD). The SSD stated having worked at this facility for only a week. The SSD stated not knowing Resident #133 or anything about an appeal for discharge. The SSD reviewed Resident #133's medical record and confirmed there was no documentation regarding the appeal. The SSD confirmed there was no record of the AHCA (Agency for Health Care Administration) discharge/transfer form. The SSD said, I do not see the AHCA discharge form. The SSD confirmed Resident #133's record did not have a documented discharge summary. During an interview on 01/08/2026 at 4:10 p.m., the Nursing Home Administrator (NHA), stated the social services department is the one who discusses the discharge with the residents. The NHA stated they should do an assessment and add notes to the record related to the discharge. The NHA stated if a resident files an appeal they should not be discharged from the facility until after the appeal decision. She said, I believe you when you tell me there is nothing in the record related to the discharge. We did not have someone in social services and the people who were covering were not doing them correctly. Review of the facility policy titled Discharge Planning,</p> <p>(continued on next page)</p>		

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:  106155	Facility ID:  106155  If continuation sheet Page 1 of 5

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  106155	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/08/2026
NAME OF PROVIDER OR SUPPLIER  Victoria Crossing Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  701 Victoria St Brandon, FL 33510	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0627</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>with a revision date of 03/10/2023 revealed a purpose: The facility shall have a discharge planning process that focuses on the residents discharge goals, the resident support system, and the transition timing to ensure a smooth process.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  106155	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/08/2026
NAME OF PROVIDER OR SUPPLIER  Victoria Crossing Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  701 Victoria St Brandon, FL 33510	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.</p> <p>Based on record review and interview, the facility failed to document the required discharge/transfer notifications and the reason for discharge for one resident (#133) out of four residents reviewed for discharge. Findings Included: Review of Resident #133's admission record revealed an admission date of 10/01/2025 and a discharge date of 11/04/2025. Resident #133 was admitted to the facility with diagnosis to include orthopedic aftercare following surgical amputation, other acute osteomyelitis, left ankle and foot, chronic obstructive pulmonary disease, and muscle weakness. Review of Resident #133's electronic medical record revealed no documentation regarding required elements for discharge per policy. An interview was conducted on 01/08/2026 at 3:56 p.m. with the Social Services Director (SSD). The SSD stated having worked at this facility for only a week. The SSD stated not knowing Resident #133 or anything about an appeal for discharge. The SSD reviewed Resident #133's medical record and confirmed there was no documentation regarding the appeal. The SSD confirmed there was no record of the AHCA (Agency for Health Care Administration) discharge/transfer form. The SSD said, I do not see the AHCA discharge form. The SSD confirmed Resident #133's record did not have a documented discharge summary. During an interview on 01/08/2026 at 4:10 p.m., the Nursing Home Administrator (NHA), stated the social services department is the one who discusses the discharge with the residents. They should do an assessment and add notes to the record related to the discharge. Residents should be notified no less than two days before the discharge. There should be a meeting documented with the resident about their discharge plan. I believe you when you tell me there is nothing in the record related to the discharge. We did not have someone in social services and the people who were covering were not doing them correctly. Review of the facility policy titled Discharge Planning, with a revision date of 03/10/2023 revealed a purpose: The facility shall have a discharge planning process that focuses on the residents discharge goals, the resident support system, and the transition timing to ensure a smooth process. Procedure: 1. in development of the discharge plan a resident, the facility shall consider the residents discharge goals, resident support available in a safe discharge environment. a. The interdisciplinary team, the family/resident representative along with the resident should be a part of the process of developing the discharge plan. 1. Periodic reevaluation of the plan should be done to address any changes in the plan that may require modification of the plan. 5. The facility shall develop a discharge summary that includes the following: a. A post discharge plan of care that has been developed with the resident or residence representative that indicates where resident is intending to reside in any arrangements made post discharge for follow up care and post discharge medical and non-medical services. b. A summary of the residents stay that includes diagnosis, treatment or therapy, and pertinent lab, radiology and consultant results. 6. The discharge summary should be available for release to authorized persons or facilities with the consent of the resident or residence representative.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  106155	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/08/2026
NAME OF PROVIDER OR SUPPLIER  Victoria Crossing Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  701 Victoria St Brandon, FL 33510	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, record reviews, and interviews the facility failed to provide toileting needs for one (#97) of two residents sampled for bladder and bowel incontinence. Findings included: On 1/6/26 at 9:13 a.m. Resident #97 was observed lying in bed. The resident reported to being wet, had not been changed since 5:00 a.m., and normally does not get changed until staff dress around 11:00 a.m. An interview was conducted with Staff O, Central Supply/Certified Nursing Assistant (CNA) on 1/7/26 at 8:52 a.m. The staff member reported the process in morning was to receive report from 11 p.m.-7a.m. shift, rounds on residents to ensure they are clean, and if wet, changed them at that time. Staff O stated Resident #97 was a heavy wetter, checks residents for incontinence every 2-3 hours, checks heavy wetter's more often. On 1/7/26 at 9:08 a.m. Resident #97 was observed lying in bed eating breakfast. The smell of urine was noticeably in the resident room while conducting an observation of medication administration with the resident's roommate. On 1/7/26 at 11:01 a.m. Resident #97 reported buying a medicated barrier cream for incontinence and the facility does provide another type. The resident reported having open areas in groin area and staff do change Resident #97 multiple times. An observation was conducted with Staff P, Licensed Practical Nurse (LPN) of the groin area of Resident #97. The observation showed the resident's incontinence brief appeared to be dry and the groin area outside of the brief was excoriated. Staff P provided incontinence care for Resident #97. Review of a 14-day lookback for Resident #97s Bladder function Certified Nursing Assistant (CNA) documentation showed the following:12/26/25: documentation of 2 episodes of continent bladder function at 6:17 p.m. with no further documentation during the 3 p.m. - 11 p.m. shift.12/27/25: documentation of 5 episodes of incontinence between 2:02 p.m. and 4:31 p.m. (2 hours 29 minutes) with no further documentation during the 3 p.m. - 11 p.m. shift.12/28/25: documentation of 3 episodes of incontinence at 10:04 p.m.12/29/25: documentation showed the resident had 6 episodes of incontinence between 10:04 p.m. (12/28/25) and 12:11 a.m. on 12/29/25 (2 hours 7 minutes). No other documentation of bladder episodes during the 11 p.m. - 7 a.m. shift.12/30/25: documentation of 2 episodes of incontinence at 5:36 p.m., no further bladder episodes during the 3 p.m. - 11 p.m. shift.12/31/25: documentation of 3 episodes at 2:36 a.m. no further documentation of bladder function on the 11 p.m. - 7 a.m. shift. Staff documented the resident had 8 episodes of incontinence prior to 10:02 a.m. (no further documentation of bladder function during the 7 a.m. - 3 p.m. shift) and no documentation of bladder episodes on the 3 p.m. - 11 p.m. shift.1/1/26: Documentation of 2 episodes of incontinence at 1:11 a.m. (14 hours and 51 minutes after the last documentation of bladder functioning.1/2/26: documentation of 1 episode of during the 11 p.m. - 7 a.m. shift. The last documentation of bladder function showed 1 episode between 2:59 p.m. and 7:55 p.m. No further documentation on 1/2/26.1/3/26: documentation of 2 incontinent episodes at 6:46 a.m. and 2 episodes at 2:35 p.m. No further documentation of bladder function on 1/3/26.1/4/26: documentation of 3 episodes of incontinent bladder function at 2:47 p.m. (24 hours and 12 minutes after last documentation on 1/3/26. 3 episodes were documented at 8:04 p.m.1/5/26: no documentation of voiding from 8:04 p.m. (1/4/26) until 2 episodes on 2:59 p.m. No documentation of voiding on 11 p.m. - 7 a.m. shift. Review of Resident #97s admission Record showed the resident was admitted on [DATE]. The record included diagnoses not limited to multiple sites (of) other specified arthritis, unspecified chronic obstructive pulmonary disease, and unspecified heart failure. Review of Resident #97s comprehensive Minimum Data Set, dated [DATE] showed the resident scored 12 of 15 on the Brief Interview of Mental Status (BIMS), indicating an intact cognition. The assessment revealed the resident was always incontinent</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  106155	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/08/2026
NAME OF PROVIDER OR SUPPLIER  Victoria Crossing Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  701 Victoria St Brandon, FL 33510	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>of urine and bowel. Review of Resident #97s care plan revealed the resident was incontinent of bladder related to impaired mobility and instructed staff to check and chance (change) as needed for incontinence. Wash, rinse, and dry perineum. Review of the resident focuses showed the resident was on diuretic therapy related to edema and had an Activity of Daily Living (ADL) self-care performance deficit related to impaired mobility which required assistance of one staff member for turning and repositioning in bed, for personal hygiene and oral care, and for toileting. An interview was conducted with Staff D, Licensed Practical Nurse (LPN)/Unit Manager (UM) on 1/8/26 at 3:51 p.m. The staff member stated CNAs document in the plan of care (POC) and normally document at the time the task is completed, staff are to document after each episode or soon after [incontinence], and if done at end of shift they may forget [what has occurred]. The UM stated CNA's work 8 hour shifts: 7 a.m. - 3 p.m., 3 p.m. - 11 p.m., and 11 p.m. - 7 a.m. and each shift documents in the POC. Staff D stated if a resident voiced a refusal to be changed, staff were to wait a minute and reapproach, second refusal - have someone else go in and ask, the third refusal a nurse goes in with staff to the resident. Staff D stated Resident #97 was able to make needs known. The staff member reviewed the bladder function task for the resident and reported seeing the issue with the CNA documentation [missing shifts]. During an interview on 1/8/26 at 6:11 p.m. the Director of Nursing (DON) stated we ask that they do it [document] as it happens, it's hard to keep up if they do care and care then come back to it. The DON stated staff should be rounding every 2 hours on residents and make frequent rounding and per request. The DON stated Resident #97 was able to tell staff when wet or not. Review of the CNA POC task for bladder function was conducted with the DON, who confirmed staff were not documenting toileting episodes and if it was not documented it was not done.</p>		